MIAMI-DADE COUNTY
RYAN WHITE TITLE I PROGRAM
COORDINATED CASE MANAGEMENT STANDARDS OF SERVICE

In addition to the System-wide Standards of Care applicable to all Title I providers, the following program specific standards apply to **case management providers only**. These standards are an essential component of the Ryan White Title I quality management program and form the basis on-going monitoring and evaluation of Title I funded case management providers by the Miami-Dade County Office of Management and Budget and/or its authorized representatives.

With the exception of staff qualifications *(Standard #1)*, it is not expected that contracted organizations be in full compliance with the Case Management Standards of Service at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. During contract negotiations, each case management provider is expected to set time specific goals for their organization's progress towards compliance with the standards in the form of a work plan. This work plan may be revised by the provider throughout the year with the prior written approval of the County. Revisions may be requested only if circumstances outside the provider's control impede its ability to achieve compliance with the standards by the target dates indicated in the originally approved work plan.

Case management is a range of client-centered services that links clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's needs, personal support systems, and case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate.

Case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring and evaluating available options and services. Case management addresses situational needs and promotes continuity of care for the client. Case management is predicated upon patient empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services.

The purpose and goals of case management are: 1) to coordinate services across funding streams; 2) to reduce service duplication across providers; 3) to assist the client with accessing services; 4) to use available funds and services in the most efficient and effective manner; 5) to increase the client's adherence to the care plan (i.e., medication regimen) through counseling; 6) to empower clients to remain as independent as possible; 7) to improve service outcomes; and 8) to control cost while ensuring that the client's needs are properly addressed.

Staff Qualifications

Standard #1

All case management supervisors, case managers and peer counselors shall have sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population.

Guidelines	Indicators	Data Source
(1.1 – 1.8) All supervisors, case managers and peer counselors must meet the qualifications of education and experience required by the Miami-Dade County Office of Management and Budget and the Miami-Dade HIV/AIDS Partnership.	Supervisors: 1.1 Master's degree OR Bachelor's degree with 5 years work experience in HIV/AIDS. 1.2 HIV/AIDS and supervisory experience preferred. Case Managers:* 1.3 Bachelor's degree in a social science area , OR Bachelor's of Science in Nursing (BSN) degree with 6 months of case management experience, OR Bachelor's degree not in a social science with 1 year of case management experience. 1.4 Knowledge of HIV/AIDS disease and the Miami-Dade HIV/AIDS service delivery system preferred 1.5 Completion of a proficiency test based on required system-wide training within 12 mos. of hire * *An individual in a case management position prior to the effective date of these standards may substitute applicable experience on a year-to-year basis for the required education.* Peer Counselors 1.6 High school degree 1.7 1 year's experience in HIV/AIDS services 1.8 Training on HIV funding streams	➢ Personnel files • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Proof of knowledge on funding streams • Training Certificate • Copy of degree • Documentation of HIV/AIDS service system experience (letters of reference, documented telephone interview) • Proof of training on funding streams

Training

Standard #2

To ensure the highest level of case management service, supervisors, case managers and peer counselors, through initial and ongoing monthly trainings, shall be continuously updated on changes in HIV/AIDS health care, the community-wide service system (services and limitations), community resources, local, state and federal programs in the area.

Guidelines	Indicators	Data Source
(2.1 – 2.5) Case management supervisors, case managers and peer counselors shall comply with all training requirements mandated and approved by the Miami-Dade County Office of Management and Budget and the Miami-Dade HIV/AIDS Partnership.	Case management supervisors, case managers and peer counselors shall complete: 2.1 HIV/AIDS 104[1] within 1 month of hire 2.2 HIV/AIDS 500[1] and 501[1,2] within 6 months of hire	➢ Personnel files • 104 Certificate dated within 1 month of hire • 500 Certificate dated within 6 months of hire • 501 Certificate dated within 6 months of hire
	2.3 Case management supervisors: 40 hours of CEU-type annual training approved by the County with 20 of the 40 hours in management training	• Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training.
	2.4 Case managers and peer counselors: 40 hours annually of monthly system-wide case management related training approved by the County	• Agency training record • Case management system- wide attendance logs
	2.5 In addition to the training hours in 2.4, case managers and peer counselors in the Ryan White Title I System less than 2 yrs: 20 hours of basic case management training[1]	• Training Certificate
(2.6) Case managers and peer counselors shall maintain all updated materials and lists of resources provided at trainings.	2.6 Provider/service listings, updated Ryan White Title I Case Management Handbook, other training materials as appropriate	• Training agendas • On-site inspection/observation

[1] *104, 500, 501 and basic case management training are not part of the 40-hour system-wide training requirement (item 2.4).*

[2] *If counseling and testing are part of the case manager's job duties, an annual 501 update is required.*

No Barriers to Service

Standard #3

Client access to case management and peer counseling services shall be facilitated in a timely and orderly manner.

Guidelines	Indicators	Data Source
(3.1 – 3.2) Initial intake and financial eligibility assessment initiated.	No later than 2 workdays from a request for service or receipt of referral: 3.1 Appointment made for intake/financial eligibility assessment 3.2 Case manager assigned	➢ Record review • Intake/financial eligibility forms dated within 5 days of filed referral or date of service request AND • Intake progress note reflects: Date of referral or service request and date of intake/financial eligibility assessment • Record reflects name of assigned case manager and date of assignment
(3.3) If client wishes to meet with a peer counselor, an appointment is facilitated.	3.3 Meeting will take place no later than 24 hours from the date of request for service or receipt of referral.	➢ Record review • Dated progress note reflects date of referral OR date of request for service AND service rendered or refused per progress note from peer counselor documenting appointment completed or appointment declined. *(See Standards #4 and #5)*

Eligibility and Financial Assessment *

Standard #4

A comprehensive eligibility and financial assessment shall be completed taking into account all funding streams and services for which the client may qualify: the client's education and orientation to the service delivery system and to client rights and responsibilities shall be initiated.

Guidelines	Indicators	Data Source
(4.1 – 4.10) Eligibility and financial assessment shall ensure all required documents are present and filed in the eligibility section of the record. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws, choice of providers, explanation of grievance procedures, Client Bill of Rights and Responsibilities.	No later than 5 workdays from receipt of referral or date of request for service, the following shall be completed: 4.1 Client Chart/Record Face Sheet 4.2 Composite Consent (includes Client Bill of Rights and Responsibilities) 4.3 Consent to Release and Exchange Information (SDIS) 4.4 Proof of HIV 4.5 Proof of Income 4.6 Financial Assessment 4.7 Proof of Miami-Dade County residency 4.8 Picture ID 4.9 Social Security (if client has SS Number) 4.10 Eligibility screening for third party payers	➢ Record review • All required forms are complete, initialed, dated, signed as appropriate. • Copies of required eligibility documents are present and legible. • Documentation of eligibility screening for third party payers is present. *(See Standard #11, 11.1 – 11.4)*

* *Eligibility and financial assessment need not be done by a case manager. This function may be performed by a trained eligibility clerk or a peer counselor with the appropriate training to conduct financial assessment and eligibility screening.*

Initial Client Assessment and Plan of Care

Standard #5

The case manager shall develop a comprehensive and individualized Needs Assessment and Plan of Care: orientation and education in the service delivery system shall continue: the client shall be assisted to access timely, appropriate services: medication adherence shall be reinforced and medical information necessary to appropriately serve the client shall be obtained.

Guidelines	Indicators	Data Source
(5.1 – 5.3) An initial comprehensive assessment and plan of care shall be completed for all case management clients to include: Adherence assessment with appropriate client referrals to existing adherence programs as part of the POC. Referrals to the University of Miami for pregnant women shall be made within 24 hours of initial contact with the case manager. (5.4 – 5.8) All referrals shall be documented in the POC. *(Applies to the referring agency.)*	No later than 5 workdays from completion of the eligibility/financial assessment the case manager shall complete: 5.1 Initial Comprehensive Assessment 5.2 Initial Plan of Care (POC) 5.3 Referrals Referrals documented in the POC will include: 5.4 Date and purpose of referral 5.5 Frequency of the requested service (how often the requested service is needed) 5.6 Provider of the requested service (agency receiving the referral) 5.7 Date of appointment 5.8 Date of follow up	➢ Record review ➢ SDIS review • Completed, dated, signed (case manager and client) comprehensive assessment • Completed, dated, signed (case manager and client) POC based on needs identified in the comprehensive assessment • SDIS Referral Report *(See Standards# 6, 6.2 – 6.9; 11, 11.1 – 11.4)*
(5.9) The client will be scheduled to meet with a peer counselor, unless the client refuses and the refusal is documented.	5.9 Progress note reflecting date of appointment with a peer counselor or documentation an appointment was refused.	➢ Record review • Progress notes

Guidelines	Indicators	Data Source
(5.10 – 5.11) Case managers shall ensure all required medical data is complete, legible, dated, filed in the appropriate section of the client record and entered into the SDIS.	5.10 Medical Certification of Diagnosis The case manager shall obtain Medical Certification of Diagnosis within 30 days of completion of the initial POC. The form shall be filed in the client record and the information entered into SDIS within 24 hrs of availability. 5.11 Quarterly/Annual Lab Results The case manager shall obtain initial (using Quarterly/Annual Lab Results Form) quarterly labs within 30 days of completion of the initial POC: the form shall be filed in the client record and the information entered into the SDIS within 24 hrs. of availability.	➢ Record review ➢ SDIS review ➢ Record review ➢ SDIS review
(5.12) Applications for eligibility under entitlement and benefit programs must be completed and filed with the appropriate entities.	5.12 Within 45 days of completion of eligibility and financial screening: dated, signed copies of applications, referral and progress note reflecting screening and submission of forms.	➢ Record review • POC • Progress notes • SDIS
(5.13) A progress note shall document the needs assessment and POC.	5.13 Dated, signed progress note corresponding to completion date of POC	➢ Record review • POC • Progress notes

Referrals/Follow-Up

Standard #6

Case managers and Peer Educators shall follow-up to verify clients are receiving necessary services as documented in the Plan of Care and coordinate their efforts with other service providers to ensure service delivery is as seamless and unobtrusive as possible to the client. The client's satisfaction with services received shall be assessed.

Guidelines	Indicators	Data Source
(6.1) The peer counselor shall follow-up, either face to face or by telephone, within 2 weeks of his/her initial meeting with a newly enrolled client.	6.1 Dated, signed progress note	➢ Record review
(6.2 – 6.4) Certified referrals between Ryan White Title I providers shall be generated electronically through the SDIS using the Certified Ryan White Title I Referral Form and recertified as needed every 6 months.	6.2 POC 6.3 SDIS 6.4 Progress notes	➢ Record review ➢ SDIS review ➢ Record Review *(See Standard #5, 5.4 – 5.8)*
(6.5 – 6.6) Referrals to providers outside the Ryan White Title I provider network shall be printed out from the SDIS using the General Referral Form.	6.5 POC 6.6 SDIS	➢ Record review ➢ SDIS review
(6.7) Medication referrals shall note the name of the medication, dosage, strength and quantity.	6.7 POC	➢ Record review • POC
(6.8 – 6.9) Referral follow up for medications and other services shall be done in a timely way to ensure coordination and benefit of service. All follow -up shall be documented in the progress notes.	Progress notes shall reflect: 6.8 Medication referrals followed-up no later than 5 workdays from the referral date 6.9 Referrals for other services followed-up no later than 5 days from the appointment date or service delivery date.	➢ Record review • Progress notes ➢ Record review • Progress notes
(6.10) All follow up on referrals shall assess the client's satisfaction with the service.	6.10 Client satisfaction, or lack thereof, documented in progress note.	➢ Record review • Progress notes

Updates to Client Record

Standard #7

Appropriate client contact shall be maintained as needed to monitor the client's personal/medical status and the efficacy of the Plan of Care (POC) shall be assessed to ensure service needs, goals, objectives and barriers as noted in the POC are addressed.

Guidelines	Indicators	Data Source
(7.1) An update (client contact) shall be documented no less than once every 3 months, or more often as client need may dictate per documentation.	7.1 Dated, signed progress note documenting client contact and adherence monitoring.	➢ Record review • Progress notes
(7.2 – 7.3) Client medical care and compliance shall be monitored to ensure optimal health results.	7.2 Quarterly/Annual Lab Results updated every quarter with CD4 and VL entered in SDIS within 24 hours of availability. 7.3 Annual medical data entered in SDIS prior to end of the calendar year.	• Quarterly/Annual Lab Results • SDIS
(7.4 – 7.9) Financial eligibility, client chart/record face sheet, needs assessments and plans of care shall be updated no less than once every 6 months, more often as client need may dictate per documentation. The Medical Certification of Diagnosis for non-AIDS patients shall be updated every 6 months.	Dated and signed as appropriate: 7.4 Client Chart/Record Face Sheet 7.5 Financial assessments 7.6 Needs Assessments and Plans of Care 7.7 Medical Certification of Diagnosis 7.8 Progress notes 7.9 Quarterly/Annual Lab Results	➢ Record review ➢ SDIS review • Updated forms • Progress notes reflecting update and noting Medical Certification of Diagnosis has been addressed
(7.10) The Composite Consent for Enrollment shall be renewed annually. Client must sign and date the Composite Consent Form annually.	7.10 Dated, signed Composite Consent Form	➢ Record review

Documentation Standards

Standard #8

To ensure consistency and quality of care across the case management service system, standardized forms shall be used and uniform standards of documentation shall be followed.

Guidelines	Indicators	Data Source
(8.1) Standardized forms shall be used.	8.1 Required SDIS forms are complete, dated and signed as necessary, and filed in the client record.	➢ Record review ➢ SDIS review • SDIS printouts
(8.2 – 8.3) Agencies shall have available in 3 languages: Composite Consent for Enrollment (includes the Client Bill of Rights and Responsibilities), Consent to Release and Exchange Information in the SDIS	8.2 Signed, dated Composite Consents 8.3 Signed, dated Consents to Release and Exchange Information (SDIS)	➢ Record review
(8.4) All client contacts shall be documented in the progress notes no later than 24 hours after occurrence.	8.4 Dated, signed progress notes	➢ Record review
(8.5) All peer counseling and case management units of service billed to Ryan White Title I shall be documented in the client chart.	8.5 Dated, signed progress notes	➢ Record review • Progress notes • Reimbursement requests
(8.6) Documentation shall accurately record the time services began and ended and number of service units provided (15 minute encounters).	8.6 Dated, signed progress notes documenting time and units, e.g. 11:30 AM to 11:58 AM, 2 units	➢ Record review • Progress notes • Reimbursement requests
(8.7) All documentation shall be complete and legible, dated, signed and include the name and title of the individual making the entry.	8.7 All required forms and progress notes	➢ Record review • Progress notes • Forms

Quality Assurance/Performance Improvement

Standard #9

Ongoing, systematic record reviews shall be performed with feedback provided to case managers resulting in continuously improving quality of service and performance.

Guidelines	Indicators	Data Source
(9.1 – 9.4) Case management supervisors shall implement and document ongoing record reviews as part of quality assurance and performance improvement activity. Review tools will be dated and signed by the supervisor.	9.1 Record reviews conducted quarterly 9.2 No less than 40 records or 10% of Ryan White Title I population reviewed (whichever is less) 9.3 Review documents information is entered in a timely fashion, is complete, legible and appropriate 9.4 Dated, signed review tools including client identification information	➢ Record review • Review of client records • Review of supervisor's reviews
(9.5 – 9.6) Quarterly patient care review and/or quality improvement meetings shall be documented.	9.5 Meeting attendance logs 9.6 Meeting minutes reflect issues discussed, problems identified, actions for correction and a time frame for completion of same	➢ Attendance logs ➢ Minutes

Standard #10

The case manager shall carry a reasonable case load that allows the case manager to effectively plan, provide and evaluate tasks related to client and system interventions.

Guidelines	Indicator	Data Source
(10.1 – 10.2) Case loads shall be reviewed between the supervisor and case manager to determine and document caseload size.	10.1 Case review at least every 6 months 10.2 Active case load not to exceed 70 clients, not including occasional clients	➢ SDIS • Case load (print out of active case load per case manager) ➢ Administrative • Supervisory logs or records documenting case review • Case load lists (case managers)

Service Delivery Information System (SDIS)

Standard #11

Service access for clients, data collection and reporting requirements shall be facilitated by requiring all pertinent client data be entered into the SDIS in a timely manner.

Refer to Standards #4, #5, #6, #7, #8, #9, #10, and #13.

Guidelines	Indicators	Data Source
(11.1) All Ryan White Title I intake information shall be entered into the SDIS in a timely manner.	11.1 Ryan White Title I Intake information entered into the SDIS at time of initial contact.	➢ Record review ➢ SDIS review
(11.2 – 11.4) Financial eligibility, needs assessment and POC information shall be completed and entered into SDIS.	11.2 Financial eligibility, needs assessments and POCs entered into the SDIS within 24 hours of completion. 11.3 Dated, signed eligibility, assessment and POC 11.4 SDIS print outs	➢ Record review ➢ SDIS review

Permanency Planning

Standard #12

The client shall be assisted in developing a legally binding plan for care of dependents, disposition of assets and other pertinent issues in the event of personal incapacitation.

Guidelines	Indicators	Data Source
(12.1 – 12.4) No later than one year from the date of the initial POC completion, the case manager will refer clients to a legal service provider for permanency planning or document that the patient refused said service.	12.1 Plan of Care reflects referral within 1 year from initial POC 12.2 SDIS reflects referral 12.3 Permanency plan addresses care of dependents, disposition of assets, other pertinent issues. 12.4 Progress note or POC reflects patient declined permanency planning.	➢ Record review ➢ SDIS review • Needs Assessment • Plan of Care • Progress Notes • Permanency Plan • SDIS Referral Report

Case Closure/Case Transfer

Standard #13

Client records shall be closed with a case closure form; clients who wish to transfer shall be enabled to do so in a timely manner.

Guidelines	Indicators	Data Source
(13.1) Client records shall be closed with a Case Closure or Case Transfer Form. (13.2 – 13.4) Clients who wish to transfer shall be assisted to do so.	Client records shall include: 13.1 A Case Closure Form detailing the reasons for closure. Copies of client records for transfers shall be mailed: 13.2 No later than 10 days from the date of the receipt of a written request from the client or the client's legal representative. 13.3 Prior to releasing information a current Consent to Release Information must be in the record. 13.4 A completed Transfer Form.	➢ Record review ➢ SDIS review • Progress notes • Case Closure Form • Case Transfer Form • Outgoing record log • Current (at time of request) Consent to Release Information
(13.5) Closure information shall contain an address/phone number/emergency contact where the client may be reached or detail the reason why said information cannot be obtained.	13.5 Completed Case Closure or Case Transfer Form	➢ Record Review
(13.6) Case closures and transfers shall be entered into the SDIS.	No later than 24 hours after completing a closure or transfer: 13.6 Data in SDIS	➢ Record review ➢ SDIS review • Closure or Transfer Form

Program Specific Operating Requirements (PS)

Standard #PS 1

Standard	Indicators	Data Source
Case management providers must offer both case management and peer education support network services.	PS1.1 Progress notes PS1.2 Reimbursement requests	➢ Personnel files ➢ Record review ➢ SDIS

Standard #PS 2

Standard	Indicators	Data Source
Case management providers must have trilingual capabilities.	PS2.1 Progress notes PS2.2 Staff interviews	➢ Record review ➢ Personnel files ➢ Observation

Standard #PS 3

Standard	Indicators	Data Source
Case management agencies must document they have sought enrollment in PAC Waiver within 30 days of the contract execution date.	PS3.1 Copy of completed, dated application PS3.2 PAC Waiver number(s)	➢ Agency records

Standard #PS 4

Standard	Indicators	Data Source
Case management agencies shall ensure clients are aware of their rights and responsibilities.	PS4.1 Copy of the Client Rights and Responsibilities posted in a public area.	➢ Observation

Standard #PS 5

Standard	Indicators	Data Source
Case management providers shall ensure the provision of interpreters/assistance to the hearing and reading impaired.	PS 5.1 Providers shall allocate funds in their budgets to ensure provision of interpreters/assistance to the hearing and reading impaired.	➢ Budget review ➢ Invoices

Standard #PS 6

Standard	Indicators	Data Source
Providers shall ensure continuity and coordination of care across services.	PS 6.1 Providers shall maintain linkage agreements with other service providers throughout the community.	➢ Administrative Review ➢ Linkage Agreements